DISCUSSION POINTS SUMMARY
Income Equity Town hall – August 30, 2017, 6-9pm

AMA: Dr. Padraic Carr, Dr. Jeff Way and Dr. Steve Chambers (AMA-CC Co-Chairs) Mike Gormley, Jim Huston, Allan Florizone, Melissa Pennell, Cindy Trueman, Contractor – Gayle Burnett

Meeting Attendees: RF delegates, Section presidents and fees reps were invited. 43 attended in person in Edmonton and Calgary with approximately 12-15 via teleconference

High Level Summary/Key Points: Dr. Carr

- The definition of the 5 year timeline was discussed at the August 20 board meeting. Although principles can be determined now, the process must be done properly. We need a realistic time frame with achievable goals and ongoing consultation.
- The OH study has been contracted to Deloitte through the PCC and is being cost-shared with AH. An impartial independent agency, Deloitte is expected to use the same process for all sections.
- The AMA will monitor the implementation for any unintended negative impacts on patient care.
- Ongoing partnership with AH is important.
- A reallocation would be a redistribution of funds, not a cut in the Physician Services Budget.
- RF decides whether to vote on the plan or not. Ongoing support/approval/direction from RF is required for the plan to continue.
- Transparency – the board has requested a more structured approach re posting correspondence. Going forward, with permission from the section/author, feedback will be posted on the website.

Presentation: Dr. Way
A pdf version was pre-circulated, especially for the benefit of those attending via teleconference.

Meeting Discussion Points:

- The effect of ANDI on patient care - Be mindful of AMA's 'Patients First' mandate. This is an aggressive step that risks putting patients last if done haphazardly.
- Pleased that AMA is 'getting it right' and with AMA's position re transparency and posting information on the website.
- Has the AMA looked at the psychology effects of taking $ away from physicians, their relationship to the AMA and the impact on business plans? This could be an unintended consequence, which AMA will monitor closely.
- When the initial motions were presented at RF, there was >80% consensus (specialists and GPs) that inequity exists and should be addressed. Relativity, intersectional relativity, etc. have historically been discussed several times. If we don't have a timeline, it won't get done. A good explanation to RF would be required for the board to extend the timeline (if not achievable).
- Concerns with lack of transparency re the numerous RF and Special resolutions not being on the agenda for fall RF. ANDI and the IEI process should consider all RF motions pertaining to income equity, not just the 4 key motions listed at the beginning of the plan.
- RF should not be the only way income equity is achieved as this is too complex an issue.
- At the Aug 20 meeting, the board discussed the disagreement process/ governance model, which should be fair/ transparent. The process is still being worked out, however, there will also be a general membership vote/ratification.

- Data presented at RF was not accurate and included names on the charts; there could be harm from collecting this data. There was no ANDI rebuttal. Data identified specific sections, perhaps incorrectly. How can a vote on inaccurate info be considered valid?
- RF resolutions recognized that information from several different sources of data were 'best available' at the time. The intent was to obtain new data on overhead, hours of work, training and compensation before the ANDI model is actually implemented. Section names have since been removed from the data.
- Even if the data is out by 20-30%, there is still some level of inequity. The process needs to be analyzed closer, addressing concerns from all sections to ensure data collection/ analysis is correct. Communication is clear or clarified if issues arise.
- How will disagreements by sections/ multiple sections be addressed?
- The AMA has an obligation to listen to all members/delegates. Although timelines are tight, they need to be workable and achievable. Our governance model, including meetings like this, help to build consensus.
- Pleased to hear that AMA wants to get the data right. Observation (collecting the data) may influence behavior. The Hawthorne effect may apply, where study participants change their behavior and therefore bias results if they know they are being watched. Any process built on this type of data will be faulty. The methodology needs to be analyzed. Looking at other jurisdictions may be more valuable/ reliable, to ensure AB remains competitive, and may also protect patients. Why hold an RF vote after one presentation at one meeting? We don't want to lose the AB advantage; we may not be able to recruit or retain.
- Some decisions may appear to be small but could lead to unintended consequences, e.g.; After-hours fee codes. This section has not received a response from AMA re after hours. Strongly opposed to keeping the after-hours codes in and leaving the modifiers out.
- Surcharges/modifiers have been discussed. The intent is not to penalize sections whose work requires after hours.
- Why now? Historically, positive allocations have not worked to decrease the gap. Now, with the $100M claw back by AH, individuals are starting to lose $, noticeably those at the lower end of the scale. This cannot be corrected without a negative ANDI.
- Concerned re timelines and 2019 for the first implementation. Although 5 yrs may not be doable, there are significant imbalances in the system. Prefer to start with small changes now.
- There is a perception amongst most physicians that certain groups make much more than others, but these differences must consider the latest measures of overhead and other factors, hence the current OH study. The graph may shift with more recently measured data. Section names were originally included so as not to be 'not-transparent'.
- Request for AMACC to acknowledge that the mandate was based on inaccurate data at RF.
- Loss of the retention benefits affected lower income sections more.
- Proceeding with negative allocation based on inaccurate data could fracture the profession.
- Concerns with the process going forward without timely answers to questions.

- It is difficult to meet OH/hours of work timelines as per invites. How will AMA support section leaders? The timeline has been determined by the RF; AMA is working with contractors to assist with this data gathering process.
- Could Deloitte do the hours of work as well as the OH study? How will ANDI help care for ophthalmology and retina specialists? Minorities need protection also.
- Hours of work and OH studies need to work together, however, the OH study is a joint initiative between AH and AMA, while the hours of work is an AMA study.
- AB is in the top 3 provinces for physician remuneration. We will monitor and consider if ANDI changes that. Distribution of resources may be a key factor.
- Savings found in PCC's IFR was not distributed to undervalued codes, but went into general funds. Where is the assurance that gov't wont claw back more $? Where will the $20M in peer review savings go? What has AMA received for the $100M we found in savings?
- Reallocation is not a fee cut. During negotiation of the Amending Agreement, AMA agreed to find the $100M; this was not a unilateral action by gov't. $100M was an estimate only, not a guarantee. The Amending Agreement includes increased stewardship, ARPs/AARPs, a Physician Resource Plan and (under the strategic agreement) increased physician representation under one overarching agreement. Representation-wise, AMA has made important gains.
- Explain the $500M as stated by govt?
- AMA is unclear as to how the MoH arrived at $500M, but she may be referring to the difference in the trajectory of spending whereby the SOMB increased by 4.5% last year rather than the 9% of the previous year and has projected similar growth reductions into next year.
- Reconciliation of work hours and overhead; there are disparities among members of individual sections. Busy practices and corresponding AHS inefficiencies may make it difficult to calculate work hours. Efficient office based practices outside of AHS should not be penalized.
- By introducing both the SOMB rules changes and then ANDI, sections could see a double impact.
- ANDI will consider SOMB savings contributions. Results will not be known till June 2018.
- We do not want to penalize efficient offices and practices but it will be difficult to measure how one practice is efficient compared to another, providing a different service. Ideally, professional fees need to be separated from technical components. This way a 'reasonably efficient' office will be accounted for using the overhead measurement process.
- If intrasectional INRV will take 3 yrs to sort out, how can ANDI be done in 5 years?
- INRV work is complimentary to the intersectional relativity exercise. INRVs can be done in parallel to the processes of intersectional relativity.
- It is critical to look at fee codes as much as OH or it could lead to more abuse of the system.
- Peer review is also part of this process; outliers should be looked at as well.
- In the Peer review process, look at under billers as well as over billers. Concerned about a possible enforcer attitude and AMA doing AH's work for free.
- The Peer Review process (as part of the amending agreement), is an educational process. AMA does not have a policing role.
- Although allocation/reallocation is recommended by the AMA, there is a joint responsibility with govt.

- For niche specialties providing after hours work, ANDI could have devastating effects. Attach a modifier to every after hours procedure, to determine the actual care provided.
- Discussion is ongoing re modifiers to help determine the work being done.
- Will physical barriers to graduates be considered? It can cost >$1M to set up a practice.
- The Physician Resource Planning committee should help to look at the significant cost to set up businesses, as well as areas of need, eg; the right geographic distribution.
- This is an opportunity to find out what actual OHs and hours of work are for practices (eg; rural medicine). There are benefits that extend beyond the equity initiative.
- What is the fairness of process, with an OH company hired by AH and AMA? How will it be audited? Concerns with the inclusion of non-insured services in the calculation of income, inclusion of tax returns, etc. Entrepreneurship outside of Medicare is no one else's business.
- Deloitte, a reputable firm, was hired by PCC, with costs shared between AMA and AH. They will do an impartial, arms-length study, engaging with sections. Initial meetings are being arranged, with additional sessions re validation, etc. Deloitte will look at prior studies, other jurisdictions; they have access to physician OH across Canada and multiple validation methods. AMA's role is to guide the process. The RFP provides structure, deliverables, surveys and opportunities for section input, resulting in reliable data. Private vs FFS is a technical question. The process is meant to encourage true OH, with sections providing information eg; the portion of OH relating to private work so it is not erroneously applied to the public sector.
- If we have only 4.5 years left, how do we meet the timelines? Will reallocation be retroactive?
- Information available for Apr 1 will not be a full year of data.
- How will a training differential be established? Who will be appointed to a panel?
- ANDI will decrease the average specialist income. If this is not the intent, how do we find a method that makes sense?
- The methodology must incorporate complexity, years of training, the extreme variance within sections and between sections, etc. Any redistribution that benefits family physicians would reduce the specialist average, but the median specialist income will likely not go down. The initial OH and Hours of Work consultations will help design the process.
- AMA should be representative of all physicians without preferential treatment for some.
- Build accountability (choosing wisely; pay for performance; quality outcome models, etc.) into the system for a fair and equitable model or current issues will continue. AMA may be missing an opportunity to introduce an innovative way of paying physicians.
- Although this is currently not in ANDI, ARP and other areas are included.
- Physicians are disappointed with the amending agreement and lost revenues. A very small % of physicians voted. What is the status of the upcoming negotiations?
- Negotiations are underway, and an all-day meeting was held yesterday, chaired by Dr. Noel Grisdale. AMA has hired a professional negotiator, and the team is developing an opening position. There will be a major presentation at fall RF.
- What is the percentile deduction for the top 3 sections /how much will be negatively transferred?
- At this time, we do not wish to presume what the number is, or the number of members that may be affected. New data needs to be collected to answer this.

- Will ANDI address intrasectional inequities, or is it focused on intersectional? If greater inequity is found intrasectionally, does ANDI address this? Why did AMA choose a sectional rather than an individual ANDI process? A negative transfer to a whole section will affect the lower billing members in that section in a possibly unfair manner.
- ANDI does not adjust intrasectional inequity. It is only one tool to address intersectional differences. Intrasectional differences will be addressed through S-INRV, billing seminars, peer review processes and OH. We do not want to punish hard workers (possibly outlier billers) who follow the rules. Income Equity addresses the income earning capacity of a section.
- If a 3.1 difference exists between sections, but a 10-fold difference exits within a section, then AMA is doing a fundamentally incorrect process. Dermatology is a small section, with 80-90% of their fee codes owned by other sections. If they don't own the codes, how do they relinquish the fees?
- The ability or potential to earn can't be examined through individuals, only through sections. This could potentially be an issue, and AMACC is looking at editing ownership rules so that sections can influence the codes they don't own outright.
- The IEI Implementation Plan should be circulated to all RF delegates now. With so many unknowns, how can RF vote on this? Consider deferring the vote to spring 2018. There is value in considering a structured presentation and a counterpoint discussion.
- The intent is to release the plan to be seen in advance of RF. RF indicated they wanted a vote this fall; RF can choose to defer the vote if they wish. Ongoing direction and approval throughout the process is required from RF. Consultation does not end at RF. Consultation outside of RF must continue.
- The Specialty Care Alliance is a good process. Although there are concerns that the IEI process may explode into something detrimental to the AMA, it can also be a unifying experience.
- Look forward to a more complete process moving forward, with all of the correspondence posted to the website.
- AMA requires permission for previous submissions to be posted.